# CONTINUING MEDICAL EDUCATION IN THE COMMUNITY HOSPITAL*

JOHN RICHARD GAINTNER, M.D.

Associate Dean for Clinical Affairs
University of Connecticut Health Center
Farmington, Conn.

I HAVE been asked to discuss continuing medical education (CME) in the community hospital. In some respects I feel as if I were carrying coals to Newcastle because, in fact, my entire career has been spent in and around a university medical center. However, because of the types of activity in which we have been involved at the University of Connecticut over the past five years I have formed close relations with and learned a great deal from my colleagues in community hospitals. Therefore, perhaps it might not be too presumptuous of me to share with you some thoughts based on our experiences in Connecticut.

To begin I offer a quotation from Dr. J. Willis Hurst of Emory University:† "Professionalism differs from amateurism in that a professional audits his own performance, looks for deficits, and tries to correct them. An amateur doesn't take the time to do so." This is the message we have heard from preceding panelists and will continue to hear throughout this symposium. This is the why of continuing education.

If it is granted that the ultimate goal of CME is improvement in the care of patients, its direct goal is to maintain and improve in the physician the knowledge, skills, and attitudes that have been engendered during the period of formal training. Particularly important are the adding of new information and the encouraging of continued inquiry in order to foster the highest qualities of medical practice. Any educational process implies a change of behavior on the part of the student with regard to the educational material; this is true also of CME. In simpler terms, this means that a physician must constantly keep abreast of his field of medicine so that the quality of his care is of the highest order.

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†Personal communication.

In addition, there are several other objectives which are consistent with or part of the primary goal of CME. These include: maintaining physician satisfaction, providing intellectual stimulation, encouraging critical inquiry, encouraging interest and activity by the physician in community health problems, stimulating interest on the part of physicians and institutions in undergraduate and graduate educational activities, and, finally, developing interest and activity in educating non-physician health personnel.

The question then becomes how to attain these goals and objectives. There is no one way. We are dealing with a variety of factors, and especially with different people, different ways of learning, and diverse content. Therefore, it is clear that a host of different approaches to CME is needed. However, having said that, let me quickly reveal my quantitative bias. After spending almost five years—at least in part—worrying about CME at the university of Connecticut School of Medicine, I am firmly convinced that the most effective focal point for most CME programs is where doctor and patient come together. Since it is logistically difficult to approach each doctor's office, the community hospital becomes a logical place for this focus. It also appears helpful in this process to establish an intimate relation between the community hospital and the medical school, with the latter acting as an educational and consultative resource.

In Connecticut approximately 95% of all physicians have hospital staff appointments. In addition, Connecticut's community hospitals traditionally have felt a strong responsibility to promote and foster continuing education to improve the quality of the care given in their institutions. The community hospital can become the central point for evaluating the quality of care, defining needs based on assessment, and developing programs to meet those needs. Thus, the community hospital becomes the "response link" in the over-all circuit. In addition, the community hospital provides physical space for lectures, conferences, symposia, and the like. In Connecticut every community hospital also has a library; many of these contain non-print educational materials in addition to books and journals.

The other important reason for locating the emphasis for continuing education programs in community hospitals is their organizational capability. By capitalizing on their libraries, physical facilities, educational hardware and software, committee structures, availability of records,

and, in some instances, computer capabilities, and, by joining the community hospital with the academic health center with its resources, continuing education programs will benefit qualitatively and quantitatively.

The first paragraph of an Affiliation Agreement Between the University of Connecticut and the . . . Hospital states:

> Hospitals and medical schools share many goals, since patient care and medical education are necessarily interrelated and are both directed towards the achievement of better health for all people. Furthermore, the inquiring minds of students provide a stimulus for better patient care; conversely, the milieu surrounding excellent patient care is vital for the highest quality of medical education. Thus, there is a challenge and an opportunity to develop optimal and mutually beneficial relationships which will combine the concerns of the School of Medicine and the . . . Hospital for excellent education, quality patient care, productive research, and community service.

During the last seven years, 20 community and specialty hospitals have developed formal relations with the University of Connecticut School of Medicine. Other institutions have developed similar relations with Yale University School of Medicine. A continuous flow of university faculty members into the community hospitals has developed, as has a similar flow of practitioners through university-based or related programs. This, of course, is in addition to and complementary to all the many other CME programs taking place in other locations.

Last year, members of the faculty of the University of Connecticut made almost 2,000 half-day visits to community hospitals. Not all of these were directly related to continuing education, but there is little question that even those aimed primarily at medical-student and house-officer programs have a profound and positive, if indirect, effect on CME. The University of Connecticut has been working closely with many community hospitals on record format and content, medical-audit methods, and other methods for assessing the quality of care.

We believe that this model is working well in Connecticut. How transferrable it is to other parts of the country is not clear. This system is not unique; certainly many universities and community hospitals have affiliation arrangements. What *is* unique is that the program covers the entire state. Strong impetus and financial support came through the

Connecticut Regional Medical Program, beginning in 1968. The full-time physicians in community hospitals are concerned with leadership in assessing and improving the quality of care and in developing and directing educational programs. The university is viewed as an educacational resource for the community hospital, and the community hospital is viewed as a resource to the university for activities connected with the care of patients. Both medical students and house officers in programs of the University of Connecticut now spend more than 50% of their time in community hospitals. In many respects the university without walls has become a reality.

Another important aspect of the program has been the development of a cadre of teachers for CME who are members of the university faculty as well as practicing physicians based in the community. A catalog has been developed which lists all these persons and their areas of expertness and interest. This has been helpful to educational committees and directors of medical education in the community hospitals when they plan programs for the year. In most instances the system of promoting programs based on perceived needs, identified through medical audits, has been popular.

One of the most significant recent events in the greater Hartford area has been the development of the Capital Area Health Consortium, Inc. This corporation was formed by eight institutions—five general hospitals, two specialty hospitals, and the University of Connecticut Health Center Hospital and School of Medicine—to foster cooperative regional planning for improving the care of patients and health education in the greater Hartford area. The consortium board of trustees consists of 25 members: a trustee, an administrator, a medical staff member from each of the institutions, plus the dean of the University of Connecticut School of Medicine. The group, which was formally incorporated last May, operates through four primary committees: a committee of trustees, a committee of administrators, a committee of medical staff members, and an education committee. The education committee is chaired by the dean of the school of medicine and is composed of educators from each of the community hospitals. Although this group is concerned with all aspects of medical education, it will be particularly concerned with CME.

One of the exciting aids to the development of CME in the region is closed-circuit television. At present the system links three institutions:

the University Health Center in Farmington, McCook Hospital in Hartford, and the Newington Veterans Administration Hospital. Plans call for extending this communication mechanism into all the other institutions in the greater Hartford area. The system is interactive so that audio-visual participation on the part of students, house staff, faculty, and physicians based anywhere in the system can easily be achieved. Such a system is not new, but by adding it to the organizational matrix of interrelated institutions, greater facility for CME becomes possible. The potential for sharing visiting speakers, medical rounds, and other activities is great. Additionally, it will be possible to create taped programs and there are also thoughts about tying into public educational television. One day an individual physician may have such a system available in his private office. The present estimated cost to a given hospital is $30,700 for installation and $3,385 per year for operation. More than one location within a hospital would add only the cost of the hardware.

One final aspect of this subject involves the relations among the community hospital, the university medical center, and the professional societies. Much more needs to be done to bring these groups together around CME. Certainly professional standards review organizations (PSRO) have some integrating potential in this regard. What will happen remains to be seen. My major plea, however, is that these groups work together to provide the best programs and to eliminate unnecessary duplication. Such cooperation also could result in beneficial cost sharing.

The Committee on Continuing Medical Education of the Connecticut State Medical Society has been doing a fine job over the past several years in working with its county societies and individual members to promote the importance of CME in a physician's life. The committee has been designed by the American Medical Association as an accrediting authority and it has been visiting community hospitals for the purpose of reviewing and accrediting such programs where indicated. The committee has also been active in fostering cooperative efforts among the Connecticut State Medical Society, the Connecticut Hospital Association, and the two medical schools. Perhaps in the future an ongoing formal relation or organization might evolve from a combination of the interests of these four institutions.

In summary, I have attempted to convey the following message.

CME must be related to the evaluation of the quality of care. This can best be done in the community hospital where doctors and patients interact and where logistics facilitate audit and CME programs. It has proved helpful to unite the community hospital and the university as educational resources; it is to be hoped that in the future such cooperative arrangements will also involve professional societies.